

**"TREATMENT AND CRIMINAL JUSTICE"**

by

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I'll be talking this morning about "Treatment and Criminal Justice" and how they work together for the community.

But first, let me make three points about drugs and the criminal justice system.

One, The purpose of law enforcement should not be to lock up otherwise law-abiding drug users.

Two, Drug abuse does not excuse criminal behavior, and treatment should not provide a means for offenders deserving of punishment to evade it.

And three, Prisons are not the best--and far from the least expensive--venues for drug treatment.

With this in mind let's take a look at the evolving relationship between treatment and criminal justice.

It is a marriage, not so much of convenience as of necessity. And, like all marriages, it must be worked on if it is to succeed. Because, although the treatment and criminal justice communities have many of the same clients, we have different concerns and different priorities.

Our goals, however, are not necessarily different. We both seek abstinence for our clients. We want them to be drug-free and crime-free. And, hopefully, we'd like to see them employed and paying taxes as well.

But what brings us together is not our common goals. Our marriage of necessity is based upon the growth of a prison population that is overwhelmingly comprised of substance abusers.

The number of incarcerated Americans has more than doubled during the past decade. By mid-1996 the total had past one million, 600 thousand, with close to a 100 thousand Federal prisoners, more than a million state inmates, and better than half-a-million in local jails.

How many of them are drug abusers?

Well, half of all suspects arrested for felonies test positive for drugs. That's nationally. In New York City, 70 to 80 percent test positive, and I doubt the percentage is any lower in Baltimore.

Correction officials throughout the U.S. generally concede that, no matter what their offenses, the great majority of inmates in their care have serious drug problems. Most estimates range between 60 and 80 percent, and the recent study by the Center for Alcoholism and Substance Abuse put the percentages at 76 percent of state prisoners and 69 percent of federal prisoners

Prisoners themselves acknowledge this, with close to 80 percent of state prisoners reporting some illicit drug use, and more than 60 percent admitting regular use. The percentages are somewhat lower for federal prisoners--but still substantial.

Why, one may wonder, when overall drug use in the U.S. has been just about halved over the past decade, does the proportion of users in the prison population remain so high? And it is not simply because we are more strictly enforcing drug laws.

What it reflects is the persistence of heavy, high-risk drug use, for the number of "hard core" drug users has remained relatively stable throughout this period. And today, it appears to be on the rise, as the number of new heroin users tripled over the past few years.

The "hard core" is made of drug users who are not only high risk but "high cost" as well. They lay a heavy burden on society and on tax payers.

They are enormous consumers of public benefits and services, like health care, welfare, and foster care. They boost the price and lower the quality of education, destroy families, destabilize communities, and sap the economy. Their disordered behavior is manifested in all forms of violence and in criminality. So, there is no mystery about the prevalence of drug abusers in U. S. correctional facilities.

The magnitude of drug abuse there is another question. And it is not one we are necessarily eager to confront

The reason states are investing in prison treatment initiatives is not to arrest drug use within the prison walls. It is to reduce recidivism.

Drug abuse treatment in correctional institutions is not new.

One of the earliest treatment programs designed for a correctional setting was the therapeutic community--or TC--developed by Phoenix House at New York City's correctional facility on Rikers Island between 1968 and 1970.

The Rikers Island program served as model for Stay'N Out, the program developed for New York State prisons a decade later by Phoenix House and other TC providers.

It is the demonstrated success of this model, first revealed by Lipton and Wexler's classic outcome studies of Stay 'N Out, that has prompted many states to adopt the TC approach for prison treatment.

In these and subsequent studies of correctional TC's, the chief criterion of effectiveness has been reduced recidivism. And what they have revealed, over time, is a re-arrest rate of one-in-four for TC clients, compared to a two-in-five rate for a comparable but untreated population.

In addition, the TC model offers the extra inducement of increased institutional safety and security.

So, let me tell you a bit about TC treatment.

The therapeutic community comes out of AA, and both reflect concepts of mutual support and self-disclosure that were popularized by the Oxford Group Movement in Great Britain at the start of the century.

The very first therapeutic communities in America evolved from an AA chapter in California that became the Synanon program.

And it was at Synanon that I first learned the TC approach back in the mid-Sixties. I was then a young Navy psychiatrist at the Oakland Naval Hospital responsible for young men returning from Vietnam with drug, alcohol, and behavior problems.

What I saw at Synanon was how the therapeutic community focused on the individual needs of its members. This priority is critical. And this was the knowledge I brought to New York in 1967 when we opened the first Phoenix House treatment program.

Over the years, as Phoenix House and other TC treatment providers have grown, the TC model has been adapted to a variety of different settings and populations. TC-style treatment--which has traditionally been comprehensive, intensive, residential, and long-term--is now available to outpatients and in day programs. And the residential component can be short-term as well as long

The therapeutic mechanism, however, remains essentially the same and capable of fostering extraordinary changes in attitude and behavior--or, to use other terms, changes in personality and character.

What characterizes TC treatment?

First is a view of chemical dependency as a disorder of the whole person, affecting behavior, attitudes, and the management of emotions, and reflected in a variety of social and vocational deficits.

Next is the concept of the community itself as healer for treatment is an ongoing process, involving all aspects of treatment community life and all community members, residents and staff alike.

Clearly important is the self-help dynamic itself, which demands:

active involvement of clients in their own treatment,

honesty and self-revelation,

and the acceptance of confrontation as a legitimate means of eliciting both;

There is a view of right living, with a clearly articulated value system that emphasizes individual responsibility;

And a comprehensive view of recovery, with the goal of returning former substance abusers to society as fully functional men and women, socially responsible, with the job skills and life skills necessary to support their new lives.

Not every substance abusers requires or can benefit from traditional TC residential treatment. But it is the treatment of choice for high-risk, high-cost abusers of the hard core.

It is particularly appropriate for the growing number of young drug abusers now coming out of dysfunctional homes. These are young people who, as adolescents, rejected adult authority and acknowledged only the influence of their peers. They have few dreams or plans or expectations for the future.

What they require is not rehabilitation, but habilitation or socialization, for they have experienced little in the way of limit-setting and recognize few of society's ground rules.

They make up a growing proportion of those drug abusers who are most in need of treatment, can benefit most from treatment, and from whose treatment society has most to gain

But it these very drug abusers, the hard core, who tend to be most successful in avoiding treatment.

Few substance abusers of any kind seek the treatment they need. And the most dysfunctional and profoundly involved abusers, who are generally deep into denial, rarely enter treatment unless they are compelled to do so -- by their families, their employers, or the courts.

High-risk, high-cost users, most likely to be involved in crime and violence, are unlikely to have employers or family contact. For them, the criminal justice system is the primary route to treatment.

The need for coercion to bring most drug abusers to treatment creates something of a paradox, because drug abusers must play an active role in their own recovery. And this requires a kind of motivation almost none bring with them initially.

Thus, the first task of treatment is to overcome denial and generate the motivation and involvement clients must have in order to succeed. Fortunately, treatment methods of today--and the therapeutic community's residential regimen in particular--are able to accomplish this, and with clients who are initially unwilling to engage in the treatment process, who do not see themselves as addicted or see their behavior as self-destructive.

Bear in mind, however, that disordered drug abusers will not accept the treatment they require if they have less demanding alternatives. And it is rare for any drug abuser to enter treatment when other options are available.

Given their druthers, few of the drug abusers who most need TC treatment are likely to opt for it. for the TC is no joy ride. It is a demanding and highly disciplined regimen.

It fits well into the correctional setting because of its tight structure. And its full daily schedule of treatment, work, and learning is compatible with the intense supervision of correctional institutions.

In addition, TC practices and program components can generally be modified to accommodate correctional needs, for the therapeutic community is a readily adaptable modality that has proven effective in many configurations.

To get full value from TC treatment, however, requires separation of the therapeutic community from the general prison population.

And, if clients are to have the best chance to sustain treatment gains, then treatment should be continued after incarceration ends.

Phoenix House operates treatment units at prisons for men and women in New York. And this system includes a "community re-integration" component. providing both residential, day treatment, and outpatient treatment for parolees.

We have just opened, in Corcoran California, a 528-bed treatment unit at a brand new correctional facility. When inmates there complete six months of treatment they will move into our statewide "managed care" network, with its full continuum of services, from intensive residential treatment to outpatient counseling.

The reason I stress these aftercare elements is because there is no "quick fix" for substance abuse. It takes time to overcome old patterns of behavior, and it takes support to sustain treatment gains and avert relapse. Not that all aspects of treatment need necessarily be long-term or full-time. One can move from residential to outpatient to support groups. But, almost invariably, sustained successful outcome is the result of long-term involvement in the treatment process.

Increasingly, the interaction of treatment with criminal justice is taking place outside the correctional setting. It is at the margins that most innovation now occurs--not in prisons so much as after prison or instead of prison.

Underlying these innovations is the realization that, while it is clearly better to treat the substance abuse of inmates than to ignore it, prison is not the most appropriate or economical treatment site. Moreover, in many cases, society's needs are better served by treating rather than imprisoning nonviolent offenders whose criminality derive clearly and directly from drug abuse.

A broad range of interventions, including drug courts, now provide alternatives to incarceration, and there are a growing number of ways to monitor and alter the behavior of parolees.

In addition to our prison and post-prison community reintegration programs, Phoenix House runs:

- a residential relapse prevention program for parolees;

- a short-term residential program for probationers failing in outpatient treatment;

- and an intensive after-school program for youthful offenders on probation

We are also the major service provider involved in New York City's pre-trial diversion initiative for repeat felons the Drug Treatment Alternative to Prison, or D-TAP, program.

The latest study of this program by the Vera Institute of Justice found that more than 60 percent of D-TAP participants have either completed or remained in treatment. These are very positive findings and give D-TAP a retention rate half again as good as other programs of this kind.

The overall outcome for D-TAP thus far, according to the study, is a 15 percent re-arrest rate for program participants and no arrests for violent crimes.

Now, before I take on your questions, I'd like to make a few points I hope you'll bear in mind as you bring your CASS initiative on line.

The first is a plea to consider, at some point, the treatment needs of adolescents in the juvenile justice system.

Let's consider what we know about the youngsters who make up the hard core of juvenile recidivists?

We know they are precociously delinquent. They get into trouble early and come early to drug and alcohol abuse. The overwhelming majority have suffered neglect or abuse or endured domestic chaos. They are the youngsters most likely to live in poverty, to do poorly in school, to drop out, to become runaways, or throwaways. They are the children most threatened by street violence, by gang violence, and among whom substance abuse is endemic.

Next is a thought about sanctions. And it is that, in each case of non-compliance, there is the need to determine how best to secure compliance--whether a more potent disincentive is needed or a more demanding and intensive intervention.

And finally--a word about coerced treatment, for perhaps the most important thing the very first

Phoenix House correctional program was able to demonstrate was that offenders who enter therapeutic community treatment under duress are no less successful than those who enter voluntarily.

Thank you.